Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Municipality Insurance Enrollment and Change Form (FORM -1MUN)

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		/ /	666/

Name - Last | First | MI

Address | ☐ This is a new address | City | State | Zip Code

Date Entered Service / / | City or Town employed or retired from | Home Phone ( ) | Work Phone ( )

02 ☐ **HEALTH COVERAGE** | **Effective Date: / 01 /**

New Enrollment ☐ | Change ☐ | Cancel Coverage ☐

☐ **Health** (Select one of the health plans below and individual or family coverage)

Health Plan

☐ **Commonwealth Indemnity Plan Basic** CIC: ☐ Yes ☐ No — Coverage

☐ **Commonwealth Indemnity Plan Community Choice** ☐ **Harvard Pilgrim Independence Plan** ☐ **Navigator by Tufts Health Plan** ☐ **Individual**

☐ **Commonwealth Indemnity Plan PLUS** ☐ **HMO:** _____ ☐ **Family**

(write in the name of the HMO)

03 ☐ **Name Change** | Previous Name | New Name

INSURED CHANGES

FOR GIC USE ONLY: **Effective Date: / 01 /**

06 ☐ **Retirement** Date Retired / /

07 ☐ **Transfer to another Agency** Name of Agency Transferred to Effective Date / /

08 ☐ **Transfer from another Agency** Previous Agency Effective Date / /

09 ☐ **Termination Coverage (if elected)** Termination Reason

_____ Termination Date _____/_____/_____

☐ 39 -Week Layoff Coverage ☐ Deferred Retiree ☐ COBRA (must complete COBRA application) ☐ Conversion (contact carrier for application)

SIGNATURE REQUIRED

Deduction Authorization

I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

At Retirement

I hereby certify that I have filed, or intend to file, an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.

Termination

I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

• If you are applying for Health Insurance, be sure to file a Form IDF to list family members • If you are enrolling in an HMO, be sure to file an application with the Plan.

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision